AMERICAN INDIAN MEDICAL HOME
APPLICATION REQUEST FORM

♦ ***Mandatory fields must be completed, or information will be returned.***

♦ TYPE OF APPLICATION REQUEST
AIMH Application ☐ Initial Application ☐ Renewal Application

- ♦ PROVIDER NAME: _____
- ♦ PROVIDER ID # (6 digits): ☐☐☐☐☐☐
- ♦ PROVIDER PHONE #: _____
- ♦ PROVIDER FAX #: _____
- ♦ CONTACT NAME: _____
- ♦ CONTACT PHONE #: _____

Return Fax #: American Indian Medical Home, 602-256-4667

***If this fax was received in error, please contact the Provider immediately at the Provider phone number above.**